

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
 Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have one of the following diagnoses? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Attention deficit hyperactivity disorder/attention deficit disorder (ADHD/ADD) <input type="checkbox"/> Binge eating disorder (BED) <input type="checkbox"/> Fatigue associated with medical illness in palliative or end of life care <input type="checkbox"/> Fatigue associated with multiple sclerosis <input type="checkbox"/> Mental fatigue secondary to traumatic brain injury (e.g. post-concussion syndrome) <input type="checkbox"/> Narcolepsy
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication, or intolerance to any preferred alternatives for the given diagnosis? <i>(If yes, complete Section D above)</i></p>
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KAPVAY / CLONIDINE ER

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication, or intolerance to any of the following? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Guanfacine ER (generic Intuniv) <input type="checkbox"/> Atomoxetine (generic Strattera)
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LESS THAN THE FDA APPROVED MINIMUM AGE

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient unresponsive to, or has had an inadequate response to behavioral therapy? <i>(If yes, complete Section D above)</i></p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient experiencing moderate-severe continuing disturbance in function despite behavioral therapy?</p>
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MULTI-SOURCE BRAND MEDICATION REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient meet any of the following circumstances? <i>(If yes, check which applies)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> The multi-source brand is being requested because of an adverse reaction, allergy or sensitivity to a generic equivalent <input type="checkbox"/> The multi-source brand is being requested due to a therapeutic failure with the generic equivalent <input type="checkbox"/> The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient <input type="checkbox"/> Special clinical circumstances exist that preclude the use of a generic version of the multi-source brand medication for the patient
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VYVANSE

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication, or intolerance to any of the following? <i>(If yes, check which applies and complete Section D above)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> Amphetamine/dextroamphetamine salts extended-release (generic Adderall XR) <input type="checkbox"/> Methylphenidate extended-release tablet or capsule (generic Concerta or Metadate CD) <input type="checkbox"/> Atomoxetine (Strattera)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of potential for a substance abuse disorder?</p>
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CONTINUATION OF THERAPY- VYVANSE

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there rationale for needing to continue the patient on Vyvanse therapy? <i>If yes, please provide rationale:</i></p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is there documentation of positive clinical response to Vyvanse therapy?</p>
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Provider Signature: _____ **Date:** _____

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